FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026716

Facility Name: Robings Manor Rehab & Health Care

Address: 502 North Main Street (Number) Brighton (City) 62012 (Zip Code)

County: Macoupin

Telephone Number: (618) 372-3232 **Fax #** (618) 372-7117

IDPA ID Number: 371068286004

Date of Initial License for Current Owners: 01/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	25	Skilled (SNF)	25	9,125	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,456		1,836	6,292	8
9	SNF/PED					9
10	ICF	12,345	4,823		17,168	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,801	4,823	1,836	23,460	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.52%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 1,836

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	87,175	11,191	333	98,699		98,699	2,821	101,520			1
2	Food Purchase		101,723		101,723		101,723	(4,100)	97,623			2
3	Housekeeping	68,889	11,350		80,239		80,239	64	80,303			3
4	Laundry	31,009	13,561		44,570		44,570	5	44,575			4
5	Heat and Other Utilities			55,385	55,385		55,385	430	55,815			5
6	Maintenance	17,360	38,771	10,319	66,450		66,450	3,701	70,151			6
7	Other (specify):* Home Office Benefits							806	806			7
8	**TOTAL General Services**	204,433	176,596	66,037	447,066		447,066	3,727	450,793			8
	B. Health Care and Programs											
9	Medical Director			7,741	7,741		7,741		7,741			9
10	Nursing and Medical Records	663,099	69,482	700	733,281		733,281	4,667	737,948			10
10a	Therapy			203,583	203,583		203,583	3	203,586			10a
11	Activities	18,119	5,416		23,535		23,535		23,535			11
12	Social Services	40,971	364		41,335		41,335		41,335			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Benefits							647	647			15
16	**TOTAL Health Care and Programs**	722,189	75,262	212,024	1,009,475		1,009,475	5,317	1,014,792			16
	C. General Administration											
17	Administrative	65,501			65,501		65,501	19,986	85,487			17
18	Directors Fees											18
19	Professional Services			15,970	15,970		15,970	(2,193)	13,777			19
20	Dues, Fees, Subscriptions & Promotion			1,578	1,578		1,578	2,585	4,163			20
21	Clerical & General Office Expense		7,832	9,718	17,550		17,550	25,788	43,338			21
22	Employee Benefits & Payroll Taxe			150,437	150,437		150,437	1,698	152,135			22
23	Inservice Training & Educatior			621	621		621	419	1,040			23
24	Travel and Seminar			129	129		129	575	704			24
25	Other Admin. Staff Transportatior			5,226	5,226		5,226	2,090	7,316			25
26	Insurance-Prop.Liab.Malpractice			30,412	30,412		30,412	763	31,175			26
27	Other (specify):* Home Office Benefits							5,737	5,737			27
28	**TOTAL General Administration**	65,501	7,832	214,091	287,424		287,424	57,448	344,872			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	992,123	259,690	492,152	1,743,965		1,743,965	66,492	1,810,457			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Robings Manor Rehab & Health Care #0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			22,916	22,916		22,916	11,337	34,253			30
31	Amortization of Pre-Op. & Org											31
32	Interest			129,635	129,635		129,635	4,943	134,578			32
33	Real Estate Taxes			12,000	12,000		12,000		12,000			33
34	Rent-Facility & Grounds							464	464			34
35	Rent-Equipment & Vehicles			1,094	1,094		1,094	113	1,207			35
36	Other (specify):*											36
37	**TOTAL Ownership**			165,645	165,645		165,645	16,857	182,502			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,893		19,893		19,893		19,893			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,230	37,230		37,230		37,230			42
43	Other (specify):* Nonallowable Cost			39,148	39,148		39,148	(39,148)				43
44	**TOTAL Special Cost Centers**		19,893	76,378	96,271		96,271	(39,148)	57,123			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	992,123	279,583	734,175	2,005,881		2,005,881	44,201	2,050,082			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(3,392)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,664	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,471)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(280)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,163)	43		24
25	Fund Raising, Advertising and Promotiona	(5,514)	43		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(24,871)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,027)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	86,228		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 86,228		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 44,201		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Robings Manor Rehab & Health Care

ID# 0026716

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. - Part A	$ (21)	43	1
2	Labs - Part A	(3,237)	43	2
3	X-Rays - Part A	(8,683)	43	3
4	Vending Machine Expense	(70)	2	4
5	Nonallowable marketing events	(2,387)	43	5
6	Nonallowable Chamber of Commerce dues	(56)	20	6
7	Capitalize Architect Fees	(7,996)	19	7
8	Meal income offset	(2,421)	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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22				22
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,871)		49

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V		1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 2,821	$ 2,821	1
2	V		2	Food		Petersen Health Care, Inc.	100.00%	89	89	2
3	V		3	Housekeeping		Petersen Health Care, Inc.	100.00%	64	64	3
4	V		4	Laundry		Petersen Health Care, Inc.	100.00%	5	5	4
5	V		5	Utilities		Petersen Health Care, Inc.	100.00%	430	430	5
6	V		6	Maintenance		Petersen Health Care, Inc.	100.00%	3,701	3,701	6
7	V		7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	806	806	7
8	V		10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,667	4,667	8
9	V		10A	Therapy		Petersen Health Care, Inc.	100.00%	3	3	9
10	V		15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	647	647	10
11	V		17	Administrative		Petersen Health Care, Inc.	100.00%	19,986	19,986	11
12	V		19	Professional Services		Petersen Health Care, Inc.	100.00%	5,803	5,803	12
13	V		20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	2,641	2,641	13
14	Total				$			$ 41,663	$ * 41,663	14

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 25,788	$ 25,788	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	419	419	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	575	575	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,090	2,090	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	763	763	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,737	5,737	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,673	3,673	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,943	4,943	22
23	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	464	464	23
24	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	113	113	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 44,565	$ * 44,565	39

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Rehab & Health Care
provider # 0026716
12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silivis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Ce	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Cen	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Cent	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Cen	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care C	McLeansboro, IL
Newman Rehabilitation & Health Care Cente	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Cen	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Cent	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Cent	Sandwich, IL
Shelbyville Rehabilitation & Health Care Cer	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Ce	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Cente	Vandalia, IL
Watseka Rehabilitation & Health Care Cente	Watseka, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA

Related Assisted Living	
Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Mark Petersen	President	Administrative	100.00	See Schedule 7A	2	3.50	Salary	19,986	L17,C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,986		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	683,169	46	$ 82,166	$ 81,693	23,460	$ 2,821	1
2	2	Food	Patient Days	683,169	46	2,606		23,460	89	2
3	3	Housekeeping	Patient Days	683,169	46	1,857		23,460	64	3
4	4	Laundry	Patient Days	683,169	46	144		23,460	5	4
5	5	Utilities	Patient Days	683,169	46	12,513		23,460	430	5
6	6	Maintenance	Patient Days	683,169	46	107,775	81,080	23,460	3,701	6
7	7	Mgmt. Allocation of Benefits	Patient Days	683,169	46	23,459		23,460	806	7
8	10	Nursing and Medical Records	Patient Days	683,169	46	135,903	130,651	23,460	4,667	8
9	10A	Therapy	Patient Days	683,169	46	88		23,460	3	9
10	15	Mgmt. Allocation of Benefits	Patient Days	683,169	46	18,830		23,460	647	10
11	17	Administrative	Patient Days	683,169	46	582,000	582,000	23,460	19,986	11
12	19	Professional Services	Patient Days	683,169	46	168,984		23,460	5,803	12
13	20	Dues, Fees, Subs & Promos	Patient Days	683,169	46	76,921		23,460	2,641	13
14	21	Clerical & General Office	Patient Days	683,169	46	750,958	577,218	23,460	25,788	14
15	23	Inservice Training & Education	Patient Days	683,169	46	12,208		23,460	419	15
16	24	Travel & Seminar	Patient Days	683,169	46	16,731		23,460	575	16
17	25	Other Admin. Staff Transport	Patient Days	683,169	46	60,875		23,460	2,090	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	683,169	46	22,218		23,460	763	18
19	27	Mgmt. Allocation of Benefits	Patient Days	683,169	46	167,067		23,460	5,737	19
20	30	Depreciation	Patient Days	683,169	46	106,965		23,460	3,673	20
21	32	Interest	Patient Days	683,169	46	143,934		23,460	4,943	21
22	34	Rent - Facility & Grounds	Patient Days	683,169	46	13,500		23,460	464	22
23	35	Rent - Equipment & Vehicles	Patient Days	683,169	46	3,305		23,460	113	23
24										24
25	TOTALS					$ 2,511,007	$ 1,452,642		$ 86,228	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle National Bank		X	Mortgage	2206 + intr	08/31/02	$ 2,036,866	$ 1,941,990	08/31/07	Variable	$ 122,856	1
2	LaSalle National Bank		X	New Construction	Interest only	08/01/05		1,298,000	05/31/06	Variable		2
3												3
4												4
5												5
	Working Capital											
6	LaSalle National Bank		X	Working capital	Interest only	08/31/04			08/31/05	Variable	6,779	6
7												7
8												8
9	TOTAL Facility Related						$ 2,036,866	$ 3,239,990			$ 129,635	9
	B. Non-Facility Related*											
10												10
11								Home office allocation			4,943	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,943	14
15	TOTALS (line 9+line14)						$ 2,036,866	$ 3,239,990			$ 134,578	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2004 report.		$ 10,523	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2004	$ 11,131	2
3. Under or (over) accrual (line 2 minus line 1).		$ 608	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 11,392	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 12,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	8,886	8
	2001	9,338	9
	2002	9,508	10
	2003	10,522	11
	2004	11,131	12

Real estate tax accrual based on 100% of the prior year's tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor Rehab & Health Care COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0026716

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE 309-691-8113 FAX #: 309-691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-001-047-00	Lot 12, Albro Palmers etal sub div	$ 4,688.00	$ 4,688.00
2.	21-001-048-00	N Pt Lot 13 A Palmers etal sub div	$ 5,883.00	$ 5,883.00
3.	21-001-049-00	40 Ctr Lot 13 A Palmers etal sub div	$ 560.00	$ 560.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 11,131.00	$ 11,131.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization [X] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	42,108	1977	$ 25,000	1
2	Resident Care	18,797	2003	159,891	2
3	TOTALS			$ 184,891	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1977	1977	$ 340,200	$	25	$	$	$ 340,200	4
5			05 Home Office								5
6			Allocation	2005	23,378			438	438	438	6
7											7
8											8
	Improvement Type**										
9	Various			1978	357		20			357	9
10	Various			1979	62,800		25			62,800	10
11	Various			1983	27,383		20			27,383	11
12	Various			1984	3,788		20			3,788	12
13	Various			1985	4,563		20			4,563	13
14	Various			1989	6,368	202	20	318	116	6,233	14
15	Various			1991	5,525	175	20	276	101	4,525	15
16	Various			1992	14,285	458	20	714	256	9,770	16
17	Various			1995	18,999	429	20	950	521	9,655	17
18											18
19	Tile flooring			1996	991	25	20	50	25	500	19
20	Curtains			1996	3,187		20	159	159	1,524	20
21	Mini blinds			1996	358		20	18	18	173	21
22	Concrete parking lot			1996	1,250	74	20	63	(12)	593	22
23	Paving and lining parking lot			1996	8,325	494	20	416	(78)	3,779	23
24											24
25	Electrical box			1997	3,777	97	20	189	92	1,701	25
26	Medicare survey			1997	1,543		20	77	77	655	26
27	Windows			1997	1,640	42	20	82	40	697	27
28	Screen patio			1997	8,369	215	20	418	203	3,483	28
29	Seal coat parking lot			1997	675	30	20	34	4	281	29
30											30
31	Landscaping			1998	4,553	280	15	304	24	2,175	31
32	Remodeling			1998	1,822	47	20	91	44	683	32
33	Siding & windows			1998	39,885	1,023	20	1,994	971	14,955	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Outdoor sign	1999	$ 1,036	$ 92	20	$ 52	$ (40)	$ 364	37
38	Sprinkler heads	1999	2,187	56	20	109	53	763	38
39	Handicapped bathrooms	1999	23,785	628	20	1,189	561	7,027	39
40	Nurse call system	1999	3,648	94	20	182	88	1,274	40
41									41
42	Roof	1999	21,735	557	20	1,087	530	7,609	42
43	Fencing	1999	2,777	164	20	139	(25)	973	43
44	Windows	1999	1,250	32	20	63	31	441	44
45									45
46	Garage & patio	1999	15,560	399	20	778	379	5,446	46
47									47
48	Windows	2000	1,233	32	20	62	30	341	48
49	Key system	2000	1,080	34	20	54	20	297	49
50	Resurface parking lo	2000	1,950	126	20	98	(29)	539	50
51									51
52	Kitchen remodeling	2001	2,152	55	20	108	53	486	52
53	Air compressor	2001	5,900	151	20	295	144	1,328	53
54	Carpet	2001	1,221	31	20	61	30	275	54
55	New roof - shed	2001	1,320	34	20	66	32	297	55
56	Remodel skilled units	2001	5,897	151	20	295	144	1,327	56
57									57
58	Building upgrades	2002	4,937	127	20	247	120	864	58
59	Nurses station cabinets	2002	2,369	296	20	118	(178)	413	59
60									60
61	Gutters and drains	2003	3,400	297	20	170	(127)	425	61
62	Hot water heater	2003	1,932	169	20	97	(72)	242	62
63									63
64	Boiler/Hot Water	2004	1,525	373	20	76	(297)	114	64
65	ADT Smoke detector	2004	6,176	1,512	20	309	(1,203)	463	65
66	Fire Suppression System	2004	1,920		20	96	96	144	66
67									67
68	Landscaping Improvements	2005	11,483	383	20	287	(96)	287	68
69	Architect Fees	2005	7,996	45	20	200	155	200	69
70	TOTAL (lines 4 thru 69)		$ 718,490	$ 9,429		$ 12,828	$ 3,399	$ 532,849	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 718,490	$ 9,429		$ 12,828	$ 3,399	$ 532,849	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24	2005 Home Office Allocation - Land Improvement:	2005	1,351			42	42	42	24
25	2005 Home Office Allocation - Building Improvement:	2005	38			2	2	2	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 719,879	$ 9,429		$ 12,872	$ 3,443	$ 532,893	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe: Robings Manor Rehab & Health Car # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 173,108	$ 10,975	$ 17,311	$ 6,336	10	$ 92,226	71
72	Current Year Purchases	17,583	2,512	879	(1,633)	10	879	72
73	Fully Depreciated Assets	98,890					98,890	73
74	Allocation from Home Office			3,191	3,191			74
75	TOTALS	$ 289,581	$ 13,487	$ 21,381	$ 7,894		$ 191,995	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	89 Ford Van	1993	$ 10,795	$	$	$	5	$ 10,795	76
77	Facility	Hossler Van	1999	40,785				5	40,785	77
78										78
79										79
80	TOTALS			$ 51,580	$	$	$		$ 51,580	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,245,931	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,916	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,253	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,337	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 776,468	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92	Additional Resident Rooms	$ 151,614	92
93	2005 Construction	1,562,863	93
94			94
95		$ 1,714,477	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column (

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5			Home office allocation		464			5
6								6
7	TOTAL				$ 464 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,207 Description: Dish machine-557; Nursing equipment-367; Freezer-170; Home office allocation-113
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,602	$ 79,285	$	2,602	$ 79,285	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,494	48,021		1,494	48,021	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,723	76,277		2,723	76,277	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				19,498		19,498	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39(2)					395		395	13
14	TOTAL			$	6,819	$ 203,583	$ 19,893	6,819	$ 223,476	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 992,707	$ 992,707	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	398,682	398,682	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,764	1,764	6
7	Other Prepaid Expenses	89	89	7
8	Accounts Receivable (owners or related parties)	1,063,568	1,063,568	8
9	Other(specify): Security deposits	9,621	9,621	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,466,431	$ 2,466,431	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	215,178	184,891	13
14	Buildings, at Historical Cost	672,536	719,879	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	356,460	341,161	16
17	Accumulated Depreciation (book methods)	(842,305)	(776,468)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp (Constr. in Progress)	1,714,477	1,714,477	22
23	Other(specify): (Loan costs)	10,000	10,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,126,346	$ 2,193,940	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,592,777	$ 4,660,371	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 371,723	$ 371,723	26
27	Officer's Accounts Payable	55	55	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,463	65,463	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,889	11,889	31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,392	11,392	32
33	Accrued Interest Payable	6,649	6,649	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued expenses	5,206	5,206	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 472,377	$ 472,377	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,941,990	1,941,990	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Construction loan	1,298,000	1,298,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,239,990	$ 3,239,990	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,712,367	$ 3,712,367	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 880,410	$ 948,004	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,592,777	$ 4,660,371	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 254,518	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 254,518	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	625,893	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 625,892	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 880,410	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 2,216,805	1
2	Discounts and Allowances for all Level	51,294	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,268,099	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	345,665	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 345,665	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,421	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	13,316	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,138	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 17,875	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation revenue	135	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 135	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,631,774	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	447,066	31
32	Health Care	1,009,475	32
33	General Administration	287,424	33
	B. Capital Expense		
34	Ownership	165,645	34
	C. Ancillary Expense		
35	Special Cost Centers	59,041	35
36	Provider Participation Fee	37,230	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,005,881	40
41	**Income before Income Taxes (line 30 minus line 40)****	625,893	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 625,893	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,104	2,104	$ 44,760	$ 21.27	1
2	Assistant Director of Nursing	2,204	2,204	37,900	17.20	2
3	Registered Nurses	3,322	3,480	67,139	19.29	3
4	Licensed Practical Nurses	11,343	11,623	178,632	15.37	4
5	CNAs & Orderlies	34,798	35,871	314,211	8.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,598	1,891	20,457	10.82	8
9	Activity Director	2,080	2,080	18,119	8.71	9
10	Activity Assistants					10
11	Social Service Workers	3,715	3,715	40,971	11.03	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	16,765	8.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,206	10,294	70,410	6.84	15
16	Dishwashers					16
17	Maintenance Worker	2,684	2,684	17,360	6.47	17
18	Housekeepers	8,540	8,747	68,889	7.88	18
19	Laundry	5,360	5,471	31,009	5.67	19
20	Administrator	2,080	2,080	65,501	31.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,114	94,324	$ 992,123 *	$ 10.52	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	8 hours	$ 333	1(3)	35
36	Medical Director	Monthly	7,741	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	7 visits	700	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 8,774		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number: Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susie Shaw	Administrator	0	$ 65,501
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 65,501

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin		$
and Glasser, LLP	Accounting	5,600
AdminaStar Federal	Computer services	198
ADP	Computer services	976
IVANS	Computer services	408
Advanced Answers on Demand	Computer services	430
AOL	Computer services	25
A Team Computing	Computer services	90
Simple.net	Computer services	51
Emdeon Business Services	Computer services	196
Farnsworth Group	Architect fees	7,996
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 15,970

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,545
Unemployment Compensation Insurance	22,737
FICA Taxes	74,426
Employee Health Insurance	16,485
Employee Meals	1,698
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	265
Pension contributions	1,954
Employee Morale	4,025
TOTAL (agree to Schedule V, line 22, col.8)	$ 152,135

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	910
Health Care Worker Background Check	
(Indicate # of checks performed 9)	130
Miscellaneous licenses & permits	420
Miscellaneous dues & subscriptions	118
Allocated from Home Office	2,641
Less: Public Relations Expense	(56)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,163

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	129
Allocated from Home Office	575
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 704

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Rehab & Health Care
Facility # 0026716
January 1, 2005 - December 31, 2005 Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		15,970
Reclassify Architect Fees to Building Improvements		(7,996)
Allocated from Home Office		
Accounting	5,693	
Legal	110	5,803
Total (agree to Schedule V, line 19, column 8)		13,777

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4					N/A								
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost repor **No**
If YES, give association name and amount **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perioc **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **83** Line **10(3)**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreemen ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES ____ NO **N** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove
No

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **37,230**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **1,698** Has any meal income been offset agains related costs? **Yes** Indicate the amount $ **2,421**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **0**
d. Have vehicle usage logs been maintained **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjust out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm **Yes**
Firm Name: **Ginoli & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? **No** If no, please explain **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT **12:05 PM** **5/16/2006**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	44,201	equal to	44,201	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	134,578	equal to	134,578	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	12,000	equal to	12,000	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	34,253	equal to	34,253	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	464	equal to	464	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	1,207	equal to	1,207	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	203,583	equal to	203,583	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	19,893	equal to	19,893	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	447,066	equal to	447,066	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,009,475	equal to	1,009,475	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	287,424	equal to	287,424	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	165,645	equal to	165,645	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	59,041	equal to	59,041	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	37,230	equal to	37,230	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	642,642	equal to	663,099	-20,457	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	18,119	equal to	18,119	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	40,971	equal to	40,971	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	87,175	equal to	87,175	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	17,360	equal to	17,360	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	68,889	equal to	68,889	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	31,009	equal to	31,009	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	65,501	equal to	65,501	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to		0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	992,123	equal to	992,123	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	333	< or = to	333	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,741	< or = to	7,741	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	700	< or = to	700	0	O.K.	Pg20 X14..X16+	B. & C.	I7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	65,501	equal to	65,501	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	15,970	equal to	15,970	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	152,135	equal to	152,135	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,163	equal to	4,163	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	704	equal to	704	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	37,230	equal to	37,230	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	1,698	< or = to	1,698	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	1,698	equal to	1,698	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,836	equal to	1,836	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	86,228	equal to	86,228	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	3,239,990	equal to	1,941,990	1,298,000	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	11,392	equal to	11,392	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	184,891	equal to	184,891	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	719,879	equal to	719,879	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	341,161	equal to	341,161	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	776,468	equal to	776,468	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	880,410	equal to	880,410	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	625,893	equal to	625,893	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,592,777	equal to	4,592,777	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Robings Manor Rehab & Health Care
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column =====> 3
Census (Pulls from Page 2) 23,460

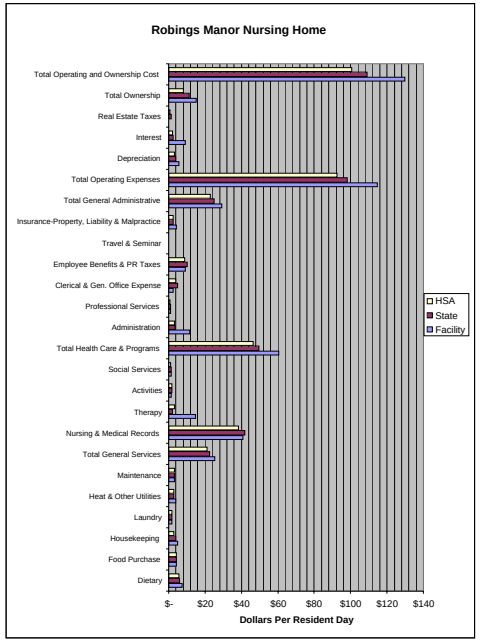
Cost Report Line	Description	Your Facility	Average Median Cost Per Day (2003) State	HSA
1	Dietary	4.33	6.01	5.50
2	Food Purchase	4.16	4.31	4.27
3	Housekeeping	3.42	3.70	2.91
4	Laundry	1.90	1.85	1.79
5	Heat & Other Utilities	2.38	2.95	2.94
6	Maintenance	2.99	3.01	2.99
8	Total General Services	19.22	22.58	21.14
10	Nursing & Medical Records	31.46	41.83	38.37
10A	Therapy	8.68	2.10	3.34
11	Activities	1.00	1.91	1.61
12	Social Services	1.76	1.42	1.05
16	Total Health Care & Programs	43.26	49.48	46.39
17	Administration	3.64	3.36	3.15
19	Professional Services	0.59	0.99	0.83
21	Clerical & Gen. Office Expense	1.85	4.79	3.98
22	Employee Benefits & PR Taxes	6.48	10.09	8.88
24	Travel & Seminar	0.03	0.08	0.10
26	Insurance-Property, Liability & Malpractice	1.33	2.58	2.35
28	Total General Administrative	14.70	24.94	23.02
29	Total Operating Expenses	77.17	98.06	92.47
30	Depreciation	1.46	3.70	3.29
32	Interest	5.74	2.54	2.09
33	Real Estate Taxes	0.51	1.38	0.82
37	Total Ownership	7.78	11.11	8.00
	Total Operating and Ownership Cost	84.95	109.17	100.47

Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the **State** and your **HSA** is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

IDHFS LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004) **UN-INFLATED**

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	**TOTAL GENERAL SERVICES**	**22.58**	**24.49**	**22.99**	**21.14**	**22.99**	**21.47**	**22.65**	**22.65**	**22.65**	**22.45**	**24.49**	**21.73**	**17.57**	**31.51**
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	**TOTAL HEALTH CARE & PROGRAMS**	**49.48**	**50.39**	**51.22**	**46.39**	**51.22**	**41.58**	**52.34**	**52.34**	**52.34**	**54.96**	**50.39**	**49.49**	**32.10**	**77.23**
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	**TOTAL GENERAL ADMINISTRATIVE**	**24.94**	**25.31**	**26.11**	**23.02**	**26.11**	**21.37**	**25.81**	**25.81**	**25.81**	**26.59**	**25.31**	**22.93**	**16.95**	**39.14**
29	**TOTAL OPERATING EXPENSES**	**98.06**	**100.77**	**100.03**	**92.47**	**100.03**	**88.05**	**100.96**	**100.96**	**100.96**	**103.01**	**100.77**	**94.71**	**69.40**	**142.56**
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	**TOTAL OWNERSHIP**	**11.11**	**9.73**	**9.80**	**8.00**	**9.80**	**7.04**	**14.54**	**14.54**	**14.54**	**11.02**	**9.73**	**8.39**	**3.76**	**23.58**
	TOTAL OPERATING & OWNERSHIP COST	**109.17**	**110.50**	**109.83**	**100.47**	**109.83**	**95.09**	**115.50**	**115.50**	**115.50**	**114.03**	**110.50**	**103.10**	**73.16**	**166.14**



	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	87,175	11,191	333	98,699	0	98,699	2,821	101,520
2. Food Purchase	0	101,723	0	101,723	0	101,723	-4,100	97,623
3. Housekeeping	68,889	11,350	0	80,239	0	80,239	64	80,303
4. Laundry	31,009	13,561	0	44,570	0	44,570	5	44,575
5. Heat and Other Utilities	0	0	55,385	55,385	0	55,385	430	55,815
6. Maintenance	17,360	38,771	10,319	66,450	0	66,450	3,701	70,151
7. Other (specify)*	0	0	0	0	0	0	806	806
8. Total General Services	204,433	176,596	66,037	447,066	0	447,066	3,727	450,793
9. Medical Director	0	0	7,741	7,741	0	7,741	0	7,741
10. Nursing & Medical Records	663,099	69,482	700	733,281	0	733,281	4,667	737,948
10a. Therapy	0	0	203,583	203,583	0	203,583	3	203,586
11. Activities	18,119	5,416	0	23,535	0	23,535	0	23,535
12. Social Services	40,971	364	0	41,335	0	41,335	0	41,335
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	647	647
16. Total Health Care & Programs	722,189	75,262	212,024	1,009,475	0	1,009,475	5,317	1,014,792
17. Administrative	65,501	0	0	65,501	0	65,501	19,986	85,487
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	15,970	15,970	0	15,970	-2,193	13,777
20. Fees, Subscriptions & Promotion	0	0	1,578	1,578	0	1,578	2,585	4,163
21. Clerical & General Office	0	7,832	9,718	17,550	0	17,550	25,788	43,338
22. Employee Benefits & Payroll	0	0	150,437	150,437	0	150,437	1,698	152,135
23. Inservice Training & Education	0	0	621	621	0	621	419	1,040
24. Travel and Seminar	0	0	129	129	0	129	575	704
25. Other Admin. Staff Trans	0	0	5,226	5,226	0	5,226	2,090	7,316
26. Insurance-Prop.Liab.Malpractice	0	0	30,412	30,412	0	30,412	763	31,175
27. Other (specify)*	0	0	0	0	0	0	5,737	5,737
28. Total General Adminis	65,501	7,832	214,091	287,424	0	287,424	57,448	344,872
29. Total General Administrative	992,123	259,690	492,152	1,743,965	0	1,743,965	66,492	1,810,457
30. Depreciation	0	0	22,916	22,916	0	22,916	11,337	34,253
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	129,635	129,635	0	129,635	4,943	134,578
33. Real Estate	0	0	12,000	12,000	0	12,000	0	12,000
34. Rent - Facility & Grounds	0	0	0	0	0	0	464	464
35. Rent - Equipment & Vehicles	0	0	1,094	1,094	0	1,094	113	1,207
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	165,645	165,645	0	165,645	16,857	182,502
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	19,893	0	19,893	0	19,893	0	19,893
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	37,230	37,230	0	37,230	0	37,230
43. Other (specify):*	0	0	39,148	39,148	0	39,148	-39,148	0
44. Total Special Cost Ce	0	19,893	76,378	96,271	0	96,271	-39,148	57,123
45. Grand Total	992,123	279,583	734,175	2,005,881	0	2,005,881	44,201	2,050,082

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	992,707	992,707
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	398,682	398,682
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,764	1,764
7. Other Prepaid Expenses	89	89
8. Accounts Receivable-Owner/Related Party	1,063,568	1,063,568
9. Other (specify):	9,621	9,621
10. Total current assets	2,466,431	2,466,431
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	215,178	184,891
14. Buildings, at Historical Cost	672,536	719,879
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	356,460	341,161
17. Accumulated Depreciation (book methods)	-842,305	-776,468
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	1,714,477	1,714,477
23. other (specify):	10,000	10,000
24. Total Long-Term Assets	2,126,346	2,193,940
25. Total Assets	4,592,777	4,660,371
CURRENT LIABILITIES		
26. Accounts Payable	371,723	371,723
27. Officer's Accounts Payable	55	55
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	65,463	65,463
31. Accrued Taxes Payable	11,889	11,889
32. Accrued Real Estate Taxes	11,392	11,392
33. Accrued Interest Payable	6,649	6,649
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	5,206	5,206
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	472,377	472,377
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,941,990	1,941,990
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,298,000	1,298,000
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,239,990	3,239,990
46.Total Liabilities	3,712,367	3,712,367
47.Total Equity	880,410	948,004
48.Total Liabilities and Equity	4,592,777	4,660,371

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,216,805
2. Discounts and Allowances for all Levels	51,294
Subtotal - Inpatient Care	2,268,099
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	345,665
7. Oxygen	0
Subtotal - Anciliary Revenue	345,665
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,421
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	13,316
20. Radiologyand X-Ray	0
21. Other Medical Services	2,138
22. Laundry	0
Subtotal - Other Operating Revenue	17,875
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	135
28. Other Revenue (specify):	0
Subtotal - Other Revenue	135
30. Total Revenue	2,631,774
31. General Services	447,066
32. Health Care	1,009,475
33. General Administration	287,424
34. Ownership	165,645
35. Special Cost Centers	59,041
35. Provider Participation Fee	37,230
37. Other	0
40. Total Expenses	2,005,881
41. Income Before Income Taxes	625,893
42. Income Taxes	0
43. Net Income or Loss for the Year	625,893